Department of HUMAN SERVICES

Jerry Foxhoven, Director

Healthy Communities Workgroup Meeting Minutes
April 15, 2019 – 2:00 p.m. - 4:00 p.m.

Welcome and Opening Remarks

Kathy Gifford, Health Management Associates, opened the meeting by referring to information provided at the January 24th and March 15th meetings regarding Community and Clinical Care Initiatives ("C3s"). She explained that the purpose of today's meeting was to drill down more deeply regarding the C3 model and discuss how and whether the model could be scaled statewide to help achieve the goals of the Healthcare Innovation and Visioning Roundtable ("Roundtable") as expressed in the recommendations submitted to Governor Reynolds in September 2018.

Presentation and Discussion: Detailed Description and Evolution of the C3 Model, Including C3 Performance Metrics and Outcomes

Angie Doyle Scar, Office of Healthcare Transformation at the Iowa Department of Public Health (IDPH), explained that the current C3 initiative was an outgrowth of the Community Care Team (CCT) pilot program begun five years ago (2014) with state appropriation funding and a contract with the Iowa Primary Care Association (IPCA). The CCT pilot was intended to explore whether the integration of community resources into community-level health care delivery systems could improve health outcomes and reduce costs. In 2016, the six CCT pilot sites were incorporated into the state's State Innovation Model (SIM) C3 initiative and were encouraged, but not required, to focus on diabetes, obesity, and tobacco cessation.
Based on guidance from the Center for Medicare and Medicaid Innovation (CMMI), in 2017 the IDPH issued a more prescriptive RFP for funding available only to the existing C3 sites. The RFP reflected a greater clinical focus with required goals, activities, and measures: C3s were required to adopt the Accountable Communities of Health (ACH) model, including greater health system involvement, and focus on improvements in diabetes health outcomes. Ms. Doyle Scar also noted that the C3s received extensive technical assistance to help them transition to the new model and meet the new requirements. Beth Riha, Division Director, Population Health Services, Iowa Healthcare Collaborative (IHC), then presented a detailed description of the current C3/ACH model that includes the following core components:

- A galvanizing vision and mission
- A multi-sectoral partnership of health care and social service providers, health plans, government agencies, and other community-based organizations and businesses
- A committed Integrator Organization that builds trust among collaborative partners and guides data driven strategies
- A Steering Committee that makes governance decisions
- Data and indicators to ensure quality
- Effective strategies and action plans
- Promotion of community member engagement
- Communications to assure understanding
- Sustainable funding to maintain gains

One Workgroup member observed that it took 4 – 6 years for the original C3s to move towards the current diabetes-focused model – starting with a care coordination/public health focus, then moving to more of a population health model, and finally transitioning to the current model that focuses on both clinical outcomes and Social Determinants of Health (SDH). Ms. Riha also noted that although the original C3s utilize local public health departments as their Integrator Organizations, the IHC sought out health systems to act as sponsors/Integrator Organizations for the more recent 14 C3 expansion sites. She indicated that as a part of the SIM grant close-out process, the IHC would be producing by the end of July a C3 "toolkit" that could be used in other communities to establish a C3 initiative.
Shelley Horak, SIM Project Manager, Iowa Medicaid Enterprise, then presented a summary of the C3 performance metrics as well as a sample of SDH data collected through the AssessMyHealth Health Risk Assessment (described in greater detail at the January 24th Workgroup meeting) used by all of the C3s and by the Medicaid managed care organizations for the expansion population. She also noted that the IDPH collects success stories on a quarterly basis from each C3. The core C3 metrics collected include:

1. Preventive Care and Screening BMI: Screening and Follow Up
2. Preventive Care and Screening: Tobacco Use: Quitline Utilization
3. Hemoglobin A1c Management
4. Adverse Drug Event Rate
5. Hospital Acquired Conditions: Clostridium Difficile
6. Preventable ED Visits, Diabetes
7. Preventable Readmissions, Diabetes
8. Total Cost of Care, Diabetes
9. Diabetes and Obesity
10. Diabetes and Tobacco Use
11. Diabetes Prevalence
12. NDPP Participation
13. DSME Program Completion
14. Social Determinants of Health Referrals

Beth Riha then presented a sample Dashboard report showing C3 trends of sample measures and also C3 Total Cost of Care results (based on Medicaid data) showing improvements in the average total medical cost per month.
Workgroup members discussed whether other metrics should be considered for future tracking and collection, especially metrics successfully used in other SIM states (e.g., Minnesota and Washington). This would allow Iowa to benchmark its performance against other states. Dr. Romano noted that the burden on providers should also be taken into consideration as some measures are more burdensome than others as they require manual collection processes. He also noted that tracking one measure alone – such as hemoglobin A1c management – may not result in the desired improved health outcomes if the health care provider is not also asking about lipid levels, obesity, exercise, etc. A more holistic measurement approach is needed. Pam Halvorson commented that uncontrolled utilization should be the basis for selecting a measure within any community.
Workgroup members also discussed opportunities for further geographic expansion of the C3 model and requested that the IHC provide a map showing the location of the current 22 C3s and the currently unserved areas. Pam Halvorson noted that when the most recent 14 C3 initiatives were added, the IHC looked for communities that were adjacent to more mature systems. Mary Lawyer commented that interested communities should be told what is expected of them (e.g., using the AHC model) and, in turn, what they can expect to get out of the initiative.

Pam Halvorson observed that it takes time and an investment of resources to implement the C3 model. With the end of SIM grant funding in April, communities will need to be able to identify other funding sources, although Bob Schlueter noted that the SIM C3 investments were relatively modest given the results and could be viewed as an economic development investment in some cases. Pam Halvorson and Mikki Stier agreed that it would be important to acknowledge the potential administrative burden for C3s that propose to rely on funding generated through grant applications. Mikki Stier also expressed an interested in the relationship of the C3 map with the Iowa Mental Health and Disability Services (MHDS) regions. Pam Halvorson also commented that the need for ongoing technical assistance should be recognized in the Workgroups recommendations with the understanding that new C3s are less likely to incorporate urban areas compared to the current C3s.

Closing and Next Steps

It was agreed that the Workgroup would develop recommendations for geographically expanding the C3 model with the goal of submitting those recommendations to the Governor in September 2019. The Workgroup directed Kathy Gifford to prepare "strawman" recommendations reflecting the meeting discussion and circulate them in advance of the next Workgroup meeting that will be scheduled sometime in June.